CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155527	B. WING			04/28/2	011
		<u> </u>	1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				160 NO	RTH MIDDLE SCHOOL ROAD		
	OLL REHABILITATION				ESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	1	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCE		DATE
F0000							
	This wisit was	for the Investigation	F00	00			
		for the Investigation	1 100	·			
	of Complaint 1	IN00089217.					
	Complaint IN(00089217					
	substantiated,						
	-	ated to the allegations					
	are cited at F2	23.					
	Survey dates:	April 28, 2011					
	F:1:41-	000522					
	Facility number						
	Provider numb	per: 155527					
	AIM number:	100267180					
	Survey team:						
	*	1 DN TC					
	Betty Retherfo						
	Delinda Easter	rly RN					
	Census bed ty	pe:					
	SNF: 9	1					
	SNF/NF: 46						
	Total: 55						
	Census payor	type:					
	Medicare: 10						
	Medicaid: 31						
	Other: 14						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JTO011

Facility ID:

000532

TITLE

If continuation sheet

OVIDER OR SUPPLIER		B. WING		04/28/2011		
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE		STREET ADDRESS, CITY, STATE, ZIP CODE 160 NORTH MIDDLE SCHOOL ROAD WINCHESTER, IN47394				
(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
Total: 55						
PineKnoll Rehwas found to be compliance wis Subpart B and regard to the InComplaint INC	th 42 CFR Part 483, 410 IAC 16.2 in evestigation of 90089217.					
rerbal, sexual, physorporal punishment declusion. The facility must not exual, or physical punishment, or inversed on reconstruction, the ensure a resident physical and versidents reviews	or tuse verbal, mental, abuse, corporal coluntary seclusion. Indicate the review and facility failed to the review and serbal abuse for 1 of 5 wed for staff to	F0223	1. Resident #B was not harr and CNA #1 was terminated. All other residents have the potential to be affected. Upor review, if abuse was noted, the employee responsible was immediately suspended and investigation started. 3. The facility's abuse policy was reviewed and no changes are indicated at this time. Facility	2. n he an		
	regulatory or record resident has the resident has the resident has the resident has the resident plunishment, or investigation. The facility must not exactly or physical unishment, or investigation and versidents reviews the residents reviews the resident treatment or record reco	rineKnoll Rehabilitation Centre vas found to be in substantial compliance with 42 CFR Part 483, subpart B and 410 IAC 16.2 in legard to the Investigation of Complaint IN00089217. Quality review completed 4-29-11 Cathy Emswiller RN The resident has the right to be free from cerbal, sexual, physical, and mental abuse, proporal punishment, and involuntary ceclusion. The facility must not use verbal, mental, exual, or physical abuse, corporal unishment, or involuntary seclusion. The facility failed to misure a resident was free from chysical and verbal abuse for 1 of 5 cesidents reviewed for staff to desident treatment in a sample of 5.	rineKnoll Rehabilitation Centre vas found to be in substantial compliance with 42 CFR Part 483, subpart B and 410 IAC 16.2 in regard to the Investigation of complaint IN00089217. Puality review completed 4-29-11 Cathy Emswiller RN The resident has the right to be free from repal, sexual, physical, and mental abuse, proporal punishment, and involuntary reclusion. The facility must not use verbal, mental, exual, or physical abuse, corporal unishment, or involuntary seclusion. The sased on record review and retrieve, the facility failed to residents reviewed for staff to resident treatment in a sample of 5.	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Total: 55 ample: 5 tineKnoll Rehabilitation Centre vas found to be in substantial compliance with 42 CFR Part 483, subpart B and 410 IAC 16.2 in regard to the Investigation of complaint IN00089217. Duality review completed 4-29-11 Cathy Emswiller RN The resident has the right to be free from reproral punishment, and involuntary seclusion. The facility must not use verbal, mental, exual, or physical abuse, corporal unishment, or involuntary seclusion. The facility failed to resident was free from thysical and verbal abuse for 1 of 5 residents reviewed for staff to resident treatment in a sample of 5.		

Diagnoses for Resident #B included, but were not limited to, Depression with agitated features, anxiety, and Alzheimer's disease. An admission Minimum Data Set Assessment, dated 2/18/11, indicated Resident #B was reviewed of the supervision of the staff for toileting. Review of a "Facility Incident Reporting Form", dated 4/7/11, included, but was not limited to, the following: "Brief Description of Incident: [Name of CNA #1] was ambulating arm and arm with the resident. When they reached [name of CNA #2]. [CNA #2].	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
STRIET ADDRESS, CITY, STATE, JIP CODE. 160 NORTH MIDDLE SCHOOL ROAD WINCHESTER, INAT394 (XA) ID SUMMARY STATIMENT OF DEPRCENCIES PREETY TAG REGULATORY OF LISE IDENTIFYING INFORMATION) Findings include: 1.) The clinical record for Resident #B was reviewed on 4/28/11 at 10:00 a.m. Diagnoses for Resident #B included, but were not limited to, Depression with agitated features, anxiety, and Alzheimer's disease. An admission Minimum Data Set Assessment, dated 2/18/11, indicated Resident #B was severely cognitively impaired and required the supervision of the staff for toileting. Review of a "Facility Incident Reporting Form", dated 4/7/11, included, but was not limited to, the following: "Brief Description of Incident: [Name of CNA #1] was ambulating arm and arm with the resident. When they reached [name of CNA #2] [CNA #1] was noted to jerk the			IDENTIFICATION NUMBER: 155527	- 1		00		
PINEKNOLL REHABILITATION CENTRE (X9 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG) FINDINGS include: Findings include: 1.) The clinical record for Resident #B was reviewed on 4/28/11 at 10:00 a.m. Diagnoses for Resident #B included, but were not limited to, Depression with agitated features, anxiety, and Alzheimer's disease. An admission Minimum Data Set Assessment, dated 2/18/11, indicated Resident #B was severely cognitively impaired and required the supervision of the staff for toileting. Review of a "Facility Incident Reporting Form", dated 4/7/11, included, but was not limited to, the following: "Brief Description of Incident: [Name of CNA #1] was ambulating arm and arm with the resident. When they reached [name of CNA #2] [CNA #1] was noted to jerk the			100027	B. WIN		ADDRESS CITY STATE ZINCODE	04/20/2	011
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PRETIX REGULATORY OR I SCIDENTIFYING INFORMATION) Findings include: 1.) The clinical record for Resident #B was reviewed on 4/28/11 at 10:00 a.m. Diagnoses for Resident #B included, but were not limited to, Depression with agitated features, anxiety, and Alzheimer's disease. An admission Minimum Data Set Assessment, dated 2/18/11, indicated Resident #B was severely cognitively impaired and required the supervision of the staff for toileting. Review of a "Facility Incident Reporting Form", dated 4/7/11, included, but was not limited to, the following: "Brief Description of Incident: [Name of CNA #1] was ambulating arm and arm with the resident. When they reached [name of CNA #2] [CNA #1] was noted to jerk the	PINEKNOLL REHABILITATION CENTRE							
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An Abuse Prohibition Review form has been implemented (See Attachment B)4. The Social Services director or Designe will interview 3 resident or 3 resident family members and 3 staff members and complete the Abuse Prohibition form on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly three after, Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.5. The above corrective actions will be completed on or before May 3, 2011 Review of a "Facility Incident Reporting Form", dated 4/7/11, included, but was not limited to, the following: "Brief Description of Incident: [Name of CNA #1] was ambulating arm and arm with the resident. When they reached [name of CNA #2] [CNA #1] was noted to jerk the	IAG	<u>'</u>		-	IAG	abuse policy (See Attachmer	nt A).	DATE
#2] [CNA #1] was noted to jerk the	TAG	Findings included. 1.) The clinical #B was review 10:00 a.m. Diagnoses for included, but we Depression with anxiety, and A and admission. Assessment, doindicated Residual Cognitively important toileting. Review of a "Free Reporting Forming For	de: al record for Resident yed on 4/28/11 at Resident #B were not limited to, th agitated features, lzheimer's disease. Minimum Data Set ated 2/18/11, dent #B was severely paired and required n of the staff for Facility Incident m", dated 4/7/11, was not limited to, the tion of Incident: A #1] was ambulating with the resident.		TAG	abuse policy (See Attachmer An Abuse Prohibition Review form has been implemented Attachment B)4. The Social Services director or Designed interview 3 residents or 3 residents or 3 residents and 3 staff members and complete the Abuse Prohibition form on scheduled work days as follo Daily for two weeks, weekly to two weeks, monthly for two months, then quarterly thereat Results of these reviews will discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.5. above corrective actions will completed on or before May	int A). (See e will ident ws: for after. be ane The be	DATE
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155527	(X5)
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 NORTH MIDDLE SCHOOL ROAD	(X5)
	(X5)
FINENING REPARTITION CENTRE I WINCHESTER IN4/394	(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	(220)
PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
[CNA #1] indicated the resident	
was squatting on the other end [the	
other end of the unit] and then	
[CNA #1] commented 'Take her to	
the Bathroom!' [Name of LPN #3]	
witnessed [CNA #1] actions and	
indicated she was abrupt and rough with the resident but doesn't think	
[CNA #1] was trying to hurt the	
resident. [LPN #3] also indicated	
[CNA #1] seemed very disgusted	
with the resident by the tone of her	
voice she was using. [CNA #2]	
indicated she had to tell [CNA #1]	
to calm down and not to handle the	
resident in that manner. [CNA #2]	
indicated [CNA #1] seemed	
frustrated but does not think [CNA	
#1] was being purposeful in her	
actions. The resident's physician	
and family were updated on the	
occurrence."	
The form indicated a head to toe	
assessment of the resident was	
completed and no injuries were	
noted. The form indicated CNA #1	
was suspended pending	
investigation and subsequently	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155527	B. WIN			04/28/2	011
NAME OF I	DDOMDED OD CUDDI IEI		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF PROVIDER OR SUPPLIER				160 NO	RTH MIDDLE SCHOOL ROAD		
PINEKN	OLL REHABILITATI	ON CENTRE		WINCH	ESTER, IN47394		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	IAG	Dia relation (DATE
		the form indicated an					
		e was completed for					
	all the staff.						
	An "Employee	e Warning" form,					
	1 1	nd signed by CNA #1					
		dicated CNA #1 had					
		ed due to a violation					
	of the code of						
	"mistreatment	of a resident."					
	An inservice a	attendance form, dated					
	1/8/11, indicate	ted CNA #1 had					
	attended an ab	ouse inservice on that					
	date.						
	Review of the	facility investigation					
		ed by the Director of					
		•					
	_	28/11 at 10:00 a.m.,					
		nvestigation had been					
	1 *	d additional staff and					
	residents had	been interviewed					
	following the 4/7/11 incident for						
	other possible	concerns of abuse					
	and none were found. The forms indicated another abuse inservice was completed following the 4/7/11 incident and the incident had been						
	reported to the	e Indiana State					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155527	A. BUI	LDING	00	COMPI 04/28/2	
		100027	B. WIN			04/20/2	:011
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE PRTH MIDDLE SCHOOL ROAL	1	
PINEKNOLL REHABILITATION CENTRE					ESTER, IN47394	,	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		ATE	COMPLETION DATE
1710	REGULATORY OR LSC IDENTIFYING INFORMATION) Department of Health.		+	ing			DATE
	Department o	i ilcuitii.					
	During an into	erview on 4/28/11 at					
	11:30 a.m., th	e Director of Nursing					
	1	did not feel CNA #1					
		to hurt Resident #B					
		s were inappropriate					
	1	able. The Director of					
	_	ated CNA #1 had					
	been terminated by the facility for						
	resident mistreatment and had not						
		any other residents					
	1	1 incident noted					
	l	1 meident noted					
	above.						
	2.) Review of	f the current facility					
	'	1/06, provided by the					
	1 * * *	ursing on 4/28/11 at					
	10:00 am, title	•					
	Prohibition, R						
	Investigation						
	1	•					
	Procedure", included, but was not limited to, the following:						
	, , , , , , , , , , , , , , , , , , , ,	7 10110 W 1115.					
	"It is the polic	cy of Hoosier					
	Enterprises that reports of abuse will be communicated to, and						
	thoroughly investigated by, the correct authority.						
		ny.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155527		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP 04/28 /2	LETED		
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 160 NORTH MIDDLE SCHOOL ROAD WINCHESTER, IN47394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	permit residen abuse by anyo employees,	g relates to complaint					